

Utah Medicaid Provider Manual	Home and Community-Based Waiver Services for Individuals 65 or Older
Division of Health Care Financing	Updated January 2007

SECTION 2

UTAH HOME AND COMMUNITY - BASED WAIVER SERVICES FOR INDIVIDUALS 65 OR OLDER PROVIDER MANUAL

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1 GENERAL POLICY

A. Under section 1915c of the Social Security Act, a State may request approval through the federal Centers for Medicare and Medicaid Services (CMS) to “waive” certain statutory requirements in order to use Medicaid funds for an array of home and community-based medical assistance services provided to eligible recipients as an alternative to institutional care. The state of Utah has provided Medicaid reimbursed Home and Community-Based Waiver Services for Individuals 65 and Older since July 1, 1992. On July 1, 2005, the Division of Health Care Financing received approval from CMS to continue operating the Home and Community-Based Waiver Services for Individuals 65 and Older (Aging Waiver) through June 30, 2010. The approval includes waivers of:

- * the “comparability” requirements in subsection 1902(a)(10)(B) of the Social Security Act, and
- * the institutional deeming requirements in section 1902(a)(10)(C)(I)(III) of the Social Security Act.

B. Waiver of Comparability

In contrast to Medicaid State Plan service requirements, under a waiver of comparability, the State is permitted to provide covered waiver services to a *limited number* of eligible individuals who meet the State’s criteria for Medicaid reimbursement in a nursing facility (NF). “Waiver services” need not be comparable in amount, duration, or scope to services covered under the State Plan. However, each year the State must demonstrate that the waiver is a “cost-effective” or a “cost-neutral” alternative to institutional (NF) services. This means that, in the aggregate, the total annual Medicaid expenditures for waiver recipients, including their State Plan services, cannot exceed the estimated Medicaid expenditures had those same recipients received Medicaid-funded NF services.

C. Waiver of Institutional Deeming Requirements

Under the waiver of institutional deeming requirements, the State uses more liberal eligibility income and resource calculations when determining recipients’ Medicaid eligibility.

1 - 1 Acronyms and Definitions

For purposes of the Aging Waiver, the following acronyms and definitions apply:

AAA	Area Agency on Aging
AGING WAIVER	Home and Community-Based Services Waiver for Individuals Age 65 and Older
CMS	Centers for Medicare and Medicaid Services
DAAS	Division of Aging and Adult Services
DAAS Designee	(Currently AAA’s. DAAS can designate a different organization if an AAA chooses not to be a designee)
DHCF	Division of Health Care Financing
HCBS	Home and Community-Based Services
ICF/MR	Intermediate Care Facility for the Mentally Retarded
NF	Nursing facility
SIP	State Implementation Plan

1 - 2 CMS Approved State Implementation Plan

- A. The State Implementation Plan (SIP) for the Aging Waiver approved by CMS serves as the State's authority to provide home and community services to the target group under its Medicaid plan. That document and all attachments constitute the terms and conditions of the program.
- B. This manual does not contain the full scope of the Aging Waiver SIP. To understand the full scope and requirements of the Aging Waiver program, the SIP should be referenced. In the event provisions of this manual are found to be in conflict with the SIP, the SIP will take precedent.

2 SERVICE AVAILABILITY

- A. Aging Waiver services are covered benefits only when provided to an individual determined to meet the eligibility criteria defined in the CMS approved Aging Waiver SIP and only pursuant to a written Comprehensive Care Plan.

2 - 1 Eligibility for Aging Waiver Services

- A. Aging Waiver services are covered benefits for a limited number of Medicaid eligible individuals for whom there is a reasonable indication that they might need the services provided in a Medicaid-certified NF in the near future unless they receive home and community-based services and for whom, but for the provision of such services, would receive the NF services, the cost of which would be reimbursed under the Medicaid State Plan.

- B. Eligibility Activities

The Division of Aging And Adult Services (DAAS) or their designee is responsible (at a minimum) for conducting the following activities:

1. Aging Waiver Application Activities (performed at the time a Demographic Intake and Screening is conducted with the individual):
 - a. Respond to inquiries by an interested individual regarding the Waiver program.
 - b. Determine whether the Waiver has available capacity within the limit delineated in Appendix G-1 (B) of the SIP.
 - c. Provide education related to the services covered by the Waiver.
 - d. Conduct an initial comprehensive assessment to determine if the individual meets level of care requirements, has an imminent need for the services provided in a nursing facility, and meets all other program eligibility requirements described in Items 2 through 6 of the Aging Waiver SIP.
 - e. Assist the individual to complete the Medicaid financial eligibility determination process.
 - f. Assist the individual to request a fair hearing if an adverse agency action is taken in relation to the Waiver application.
2. Freedom of Choice Activities (performed at the time an individual is determined to be eligible for the Aging Waiver):
 - a. Identify the general service needs of the individual.
 - b. Inform the individual of the services the Waiver program can provide and the services a Medicaid nursing facility can provide to meet the identified general needs.
 - c. Offer the individual choice of the Waiver program or the Medicaid nursing facility program and document the choice selected.
 - d. Assist the individual to request a fair hearing if choice of the Waiver program is denied.
3. Enrollment Activities (performed at the time it is determined sufficient Aging Waiver capacity is available to permit an individual to be enrolled into the Waiver):

- a. Develop an initial Comprehensive Care Plan based on the needs identified by the comprehensive assessment.
- b. Assist the individual to select a Waiver case management provider.
- c. At the intervals specified in Appendices D and E of the Aging Waiver SIP, conduct ongoing comprehensive assessments to determine if the individual continues to meet level of care requirements, has an imminent need for the services provided in a nursing facility, and meets all other program eligibility requirements described in Items 2 through 6 of the Aging Waiver SIP, and develop updated Comprehensive Care Plans.
- d. Assist the individual to request a fair hearing if choice of the Waiver case management provider is denied.

C. Mental or Physical Condition Determination

In determining whether the applicant has mental or physical conditions that can only be cared for in a nursing facility, or the equivalent care provided through the Aging Waiver, the individual responsible for assessing level-of-care shall document that at least two of the following factors exist:

1. Due to diagnosed medical conditions, the individual requires at least substantial physical assistance with activities of daily living above the level of verbal prompting, supervising, or setting up;
2. The attending physician has determined that the individual's level of dysfunction in orientation to person, place, or time requires nursing facility care; or equivalent care provided through the waiver;
3. The medical condition and intensity of services indicate that the care needs of the individual cannot be safely met in a less structured setting, or without the services and supports of the waiver.

D. Eligibility Restrictions

1. An individual will not be enrolled if it is determined during the eligibility assessment process that the health, welfare, and safety of the individual cannot be met through the Aging Waiver program.
2. Inpatients of hospitals, nursing facilities, or ICF/MRs are not eligible to receive Waiver services (except as specifically permitted for case management discharge planning in the 90-day period before their discharge to the Aging Waiver).

2 - 2 Applicant Freedom of Choice of NF or Aging Waiver

- A. Medicaid recipients who meet the eligibility requirements of the Aging Waiver may choose to receive services in a NF or the Aging Waiver if available capacity exists, to address health, welfare, and safety needs.
- B. If no available capacity exists in the Aging Waiver, the applicant will be advised in writing that he or she may access services through a NF or may wait for open capacity to develop in the Aging Waiver.
- C. If available capacity exists in the Aging Waiver, a pre-enrollment screen of health, welfare, and safety needs will be completed by DAAS or their designee. The applicant will be advised of the preliminary needs identified and given the opportunity to choose to receive services to meet the identified needs through a NF or the Aging Waiver. The applicant's choice will be documented in writing, signed by the applicant, and maintained as part of the individual record.
- D. Once the applicant has chosen to enroll in the Aging Waiver and the choice has been documented, subsequent review of choice of program will only be required at the time a substantial change in the participant's condition results in a change in the Comprehensive Care Plan. It is, however, an Aging Waiver participant's option to choose institutional (NF) care at any time and voluntarily disenroll from the Aging Waiver.

2 - 3 Aging Waiver Participant Freedom of Choice

- A. Upon enrollment in the Aging Waiver, the participant will be given choice among available Waiver case management agencies. The applicant's choice will be documented in the case record.
- B. Upon completion of a comprehensive needs assessment by DAAS or their designee, the individual will participate in the development of the Comprehensive Care Plan to address the individual's identified needs.
- C. The participant will be given choice of services to meet an identified need if more than one cost-effective option exists.
- D. The participant will be given a choice of available qualified providers of Aging Waiver services identified in the Comprehensive Care Plan.
- E. The DAAS or their designee will review the contents of the written Comprehensive Care Plan with the participant prior to implementation. The written Comprehensive Care Plan is signed by the participant and constitutes a formal notice of the agency's decision regarding authorized services to be provided to the participant.
- F. Subsequent revisions to the participant's Comprehensive Care Plan may occur as a result of the annual re-assessment or any time there is a significant change in the participant's health, welfare, or safety.
 - 1. A significant change is defined as a major change in the recipient's status that:
 - a. is not self-limiting;
 - b. impacts on more than one area of the recipient's health status; and
 - c. requires interdisciplinary review and/or revision of the Comprehensive Care Plan.

NOTE A condition is defined as self-limiting when the condition will normally resolve itself without intervention by Aging Waiver services. Generally, if the condition has not resolved within approximately two weeks, a comprehensive reassessment should begin.

- 2. A reassessment is required if significant change is consistently noted in two or more areas of decline, or two or more areas of improvement.
- 3. A Level of Care screening will also be conducted at the conclusion of an inpatient stay in a medical facility.
- G. During the review of the written service plan, the individual will be informed in writing of any decision to deny, suspend, reduce, or terminate a waiver service listed in the service plan and will be informed of the right to a fair hearing.

2 - 4 Termination of Aging Waiver Services

- A. The Division of Health Care Financing (DHCF), in partnership with DAAS, will compile information on voluntary disenrollments and routine involuntary disenrollments, and will conduct reviews of proposed special circumstance disenrollments from the Aging Waiver.
 - 1. Voluntary disenrollments are cases in which participants choose to initiate disenrollment from the Aging Waiver. These cases require written notification to the Division of Health Care Financing by DAAS or their designee within 30 days from the date of disenrollment. Documentation will be maintained by DAAS or their designee detailing the discharge planning activities completed with the Waiver participant as part of the disenrollment process.
 - 2. Pre-Approved involuntary disenrollments are cases in which participants are involuntarily disenrolled from the Aging Waiver program for any one or more of the specific reasons listed below:

- Participant death;
- Participant no longer meets financial requirement for Medicaid program eligibility;
- Participant has moved out of the State of Utah; or
- Participant whereabouts are unknown.

Pre-Approved involuntary disenrollments require written notification to the Division of Health Care Financing by DAAS or their designee within 30 days from date of disenrollment. No Division of Health Care Financing prior review or approval of the decision to disenroll is required. Documentation will be maintained by the local case management agencies detailing the discharge planning activities completed with the Waiver participant as part of the disenrollment process, as appropriate.

3. Special circumstance disenrollments are cases that are non-routine in nature and involve circumstances that are specific to the individual involved. Examples of this type of disenrollment include: the Waiver participant no longer meets the corresponding institutional level of care requirements, the participant's health and safety needs cannot be met by the current program's services and supports, or the participant has demonstrated non-compliance with the agreed upon care plan and is unwilling to negotiate a Comprehensive Care Plan that meets minimal safety standards.

Special circumstance disenrollments require review and authorization prior to disenrollment to facilitate:

- a. Appropriate movement amongst programs;
- b. Effective utilization of program potential;
- c. Effective discharge and transition planning;
- d. Provision of information, affording participants the opportunity to exercise all rights; and
- e. Program quality assurance/quality improvement measures.

The special circumstance disenrollment review process will consist of the following activities:

- a. The waiver case management agency recommending disenrollment will compile information to articulate the disenrollment rationale.
 - b. Disenrollment rationale information will be submitted to the DAAS designee for their review of the documentation of case management activities and the disenrollment recommendation. The DAAS designee will consult with DAAS to make an initial determination of the merits of the proposed disenrollment.
 - c. If DAAS management staff concur with the recommendation, the case will be forwarded to the DHCF for a final decision.
 - d. The DHCF will review and assure the available array of Aging Waiver and non-waiver services, and other available resources have been fully utilized to meet the individual's health and safety needs.
 - e. The DHCF will facilitate case staffing meetings with appropriate parties, as needed, to complete the review and make an appropriate final decision on the proposed disenrollment.
 - f. The DHCF final disenrollment decision will be communicated in writing to both the DAAS designee and the DAAS management staff.
- B. If the disenrollment is approved, the DAAS designee will provide to the individual the required written notification of agency action and right to fair hearing information.
 - C. The case management agency will initiate discharge planning activities sufficient to assure smooth transition to an alternate Medicaid program or to other services.

2 - 5 Fair Hearings

- A. The Division of Health Care Financing provides an individual applying for or receiving Aging Waiver services an opportunity for a hearing upon written request, if the individual is:
1. Not given the choice between institutional (NF) care or Aging Waiver services.
 2. Denied the Waiver provider(s) of choice if more than one provider is available to render the service(s).
 3. Denied access to Waiver services identified as necessary to prevent institutionalization.
 4. Experiences a reduction, suspension, or termination of Waiver services identified as necessary to prevent institutionalization.
- B. An individual and the individual's legal representative, as applicable, will receive a written Notice of Agency Action from DAAS or their designee if the individual is denied a choice between institutional (NF) care or Aging Waiver services, found ineligible for the Waiver program, or denied access to the provider of choice for a covered Waiver service. The Notice of Agency Action delineates the individual's right to appeal the decision.
- C. An aggrieved individual may request a formal hearing within 30 calendar days from the date written notice is issued or mailed, whichever is later. The Division of Health Care Financing may reinstate services for recipients or suspend any adverse action for providers if the aggrieved person requests a formal hearing not more than ten calendar days after the date of action.
- D. Informal Dispute Resolution
1. The individual is encouraged to utilize an informal dispute resolution process to expedite equitable solutions but may forgo or interrupt the available informal resolution process at any time by completing a request for hearing and directing the request be sent to the Department of Health, Division of Health Care Financing for a formal hearing and determination.
 2. An informal dispute resolution process does not alter the requirements of the formal fair hearings process. The individual must still file a request for hearing and a request for continuation of services within the mandatory time frames established by the Division of Health Care Financing. An informal dispute resolution must occur prior to the deadline for filing the request for continuation of service and/or the request for formal hearing, or be conducted concurrent with the formal hearing process.

3 PROVIDER PARTICIPATION

3 - 1 Provider Enrollment

- A. Aging Waiver services are covered benefits only when delivered by a provider enrolled with the State Medicaid Agency or contracted with the DAAS designee to provide the services as part of the Waiver.
- B. Any willing provider that meets the qualifications defined in the Aging Waiver SIP, Appendix B-2, may enroll at any time to provide an Aging Waiver service by contacting DAAS or their designee responsible for the day to day administration of the Waiver in the geographical area the provider desires to serve. As applicable, DAAS or their designee will facilitate completion and submission of the required Medicaid provider application. The provider is only authorized to provide the Waiver services specified in Attachment A of the Medicaid provider agreement submitted by the provider.

3 - 2 Provider Reimbursement

- A. A unique provider number is issued for each of the Aging Waiver service areas associated with the 11 participating Area Agencies on Aging. A provider that enrolls to provide Aging Waiver services in one or multiple service areas will receive an equivalent number of Medicaid provider numbers. When submitting claims for reimbursement, the provider must use the proper provider number associated with the Area Agency on Aging where the Aging Waiver recipient is receiving the services. Claims containing a provider number that is not associated with the proper Area Agency on Aging will be denied.
- B. Providers will be reimbursed according to the specified reimbursement rate(s) contained in the *Negotiated Waiver Rate Sheet* for the local Area Agency on Aging where the Waiver participant is receiving services.
- C. Providers may only claim Medicaid reimbursement for services that are ordered by DAAS or their designee. Claims must be consistent with the amount, frequency and duration ordered by DAAS or their designee.

3 - 3 Standards of Service

- A. Providers must adhere to service standards and limitations described in this manual, the terms and conditions of the Medicaid provider agreement, and the terms and conditions of the Aging Waiver SIP. In addition, providers participating in the Aging Waiver must adhere to the following requirements covering interactions with DAAS or their designee responsible for the day to day administration of the program:
 - 1. Complete a *Negotiated Waiver Rate Sheet* form for each DAAS designee in which Waiver services will be provided. An enrolled Waiver provider must update the *Negotiated Waiver Rate Sheet* when the provider's list of provided services changes or a change to a covered service reimbursement rate is negotiated.
 - 2. Submit to each applicable DAAS designee a monthly written summary report of claims submitted for Medicaid reimbursement. The summary report shall be submitted within 10 calendar days after the end of each month and shall detail for each Waiver participant the specific Waiver services provided, the units of service billed for each service, the dates of service, and the reimbursement amount billed.

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3 - 4 Provider Rights to a Fair Hearing

- A. The Department provides hearing rights to providers who have had any adverse action taken by the Utah Department of Health, Division of Health Care Financing, or DAAS or their designee, and who submit a written request for a hearing to the agency. Please refer to Utah Department of Health Administrative Hearing Procedures for Medicaid/PCN Recipients, Applicants, and Providers in Section 1, Chapter 6 - 15, Administrative Review/Fair Hearing. This includes actions of a DAAS designee relating to enrollment as a Waiver provider, free choice of available providers by Waiver participants, contract reimbursement rates, sanctions or other adverse actions related to provider performance, or improper conduct of the agency in performing delegate Waiver responsibilities.

4 PRIOR AUTHORIZATION OF WAIVER SERVICES

- A. Effective July 1, 2004, no prior authorization of Waiver covered services by the State Medicaid Agency is required. Provider participation and service delivery will be governed by Waiver quality management systems for assuring proper development and implementation of plans of care, assuring Waiver services are provided by qualified providers, and assuring financial accountability for funds paid to providers for the Waiver program.

5 CASE MANAGEMENT

5 - 1 Case Management Encounters

- A. To better focus primary attention on providing the specific level of case management intervention needed on an individualized basis, as determined during the initial and ongoing comprehensive needs assessment process, the individual Comprehensive Care Plan will be the vehicle through which the level of assessed need for case management will be detailed in terms of the objectives to be achieved, and the amount, duration, and frequency of intervention to be provided to meet the stated objectives. This approach will also promote case managers having specific information about their expected roles and responsibilities on an individualized Waiver participant basis. Program performance reviews will assess the accuracy and effectiveness of the link between the determination of need, the Comprehensive Care Plan, the implementation of case management services, and the ongoing evaluation of progress toward the stated objectives.

5 - 2 MDS-HC Assessment Instrument

- A. The InterRAI MINIMUM DATA SET - HOME CARE (MDS-HC) serves as the standard comprehensive assessment instrument used in the Aging Waiver.

6 PARTICIPANT - DIRECTED EMPLOYER AUTHORITY

- A. The participant-directed employee authority requires the Waiver participant to use a Waiver Fiscal Management Services Agent as an integral component of the Waiver services to assist with managing the employer-related financial responsibilities associated with the employer-employee relationship. The Waiver Fiscal Management Services Agent is a person or organization that assists Waiver participants and their representatives, when appropriate, in performing a number of employer-related tasks, without the participants being considered the common law employers of the service providers. Tasks performed by the Waiver Fiscal Management Services Agent include documenting service provider's qualifications, collecting service provider time records, preparing payroll for participants' service providers, and withholding, filing, and depositing federal, state, and local employment taxes.
- B. Participant employed service providers complete a time sheet for work performed. The participant confirms the accuracy of the time sheet, signs it, and forwards it to the Waiver Fiscal Management Services Agent for processing. The Waiver Fiscal Management Services Agent files a claim for reimbursement through the Medicaid MMIS system and upon receipt of payment, completes the employer-related responsibilities and forwards payment directly to the service provider for the services documented on the time sheet.

7 WAIVER COVERED SERVICES RATE SETTING METHODOLOGY

- A. The Department of Human Services (DHS) has entered into an administrative agreement with the Department of Health, Division of Health Care Financing (DHCF) to set 1915c HCBS Waiver rates for Waiver covered services. The DHS rate-setting process is designed to comply with requirements under the 1915c HCBS Waiver program and other applicable Medicaid rules. There are four principal methods used in setting the DHS Maximum Allowable Rate (MAR) level. Each method is designed to determine a fair market rate. The four principle methods are:
- existing market survey or cost survey of current providers
 - component cost analysis
 - comparative analysis, and
 - community price survey
- B. The Case Management covered Waiver service provider rate is calculated using the cost survey of current provider's methodology in general but includes an added procedure in which each fiscal year the State Medicaid Agency establishes specific cost center parameters to be used in calculating the annual MAR.
- C. Annual MAR schedules may be held constant or modified with a Cost of Living Adjustment (COLA) for any or all of the Waiver covered services in lieu of completing one of the four principle methods depending on the budget allocation approved by the Utah State Legislature for the applicable fiscal year.

8 USE OF “TN” RURAL ENHANCEMENT MODIFIER

- A. The use of the TN rural enhancement modifier is authorized in the Aging Waiver for the purpose of assuring access to Waiver covered services in rural areas of the State where Waiver service providers are required to travel extended distances to deliver services. The rate enhancement adjusts the per unit rate of reimbursement to account for the additional travel-related expenses not included in the normal rate setting process. For purposes of the rural enhancement rate, rural counties are all counties in Utah except Weber County, Davis County, Salt Lake County, and Utah County.
1. The following limitations are imposed on the use of the rural enhancement:
 - a. DAAS or their designee must authorize use of the rural enhancement rate at the time the services are ordered.
 - b. The location assigned as the provider's normal base of operation must be in a county designated as rural;
 - c. The location from which the service provider begins the specific trip must be in a county designated as rural;
 - d. The location where the service is provided to the Waiver participant must be in a county designated as rural; and
 - e. The direct distance traveled by the provider from the starting location of the trip to the Waiver participant must be a minimum of 25 miles with no intervening stops to provide Waiver or State plan services to other Medicaid recipients. When a single trip involves service encounters for multiple Waiver participants, each leg of the trip will be treated as an independent trip for purposes of qualifying for the rural enhancement (i.e. each leg must involve a direct travel distance of 25 miles or more).
 - f. When a single service encounter involves multiple services, only one of the services is authorized for the rural enhancement rate.
- B. Uniform Authorization of the Rural Enhancement Rate: It is the responsibility of DAAS or their designee to authorize any provider to bill for services using the rural enhancement code modifier. The use of the rural enhancement rate should be applied uniformly across the State according to the following guidelines:
1. If the initial authorization was verbal, DAAS or their designee will follow up with a written service authorization that includes the authorization for rural enhanced reimbursement and will provide a copy of the written authorization to the person responsible for monitoring Aging Waiver billings.
 2. DAAS or their designee is responsible to monitor the Medicaid billing statements to assure providers are appropriately using the rural enhancement rate. In the event of inappropriate use of the rural enhancement rate, the DAAS designee will notify DAAS.
 3. When possible, providers must coordinate service delivery to minimize the use of the TN modifier by combining multiple service encounters in a single trip.

9 CLAIMS AND REIMBURSEMENT

9 - 1 Time Limit to Submit Claims

- A. MEDICAID PROVIDERS BILLING UNDER A PROVIDER NUMBER FOR THE AGING WAIVER MUST SUBMIT A CLAIM FOR PAYMENT NO LATER THAN 90 DAYS FROM THE ACTUAL DATE OF SERVICE IN ORDER FOR THE CLAIM TO BE ELIGIBLE FOR PAYMENT. The allowable time frame within which an Aging Waiver claim may be filed is reduced from 12 months to 90 days in order to effectively manage the Aging Waiver's established annual budget allocation, to assure funds available during each fiscal year are properly allocated to eligible Medicaid recipients, and to provide an increased level of quality oversight for the care plan implementation process.
- B. THIS CHANGE ONLY AFFECTS CLAIMS FOR THOSE SPECIFIC SERVICES COVERED BY THE AGING WAIVER PROGRAM AND BILLED UNDER THE PROVIDER NUMBER ASSIGNED FOR THE AGING WAIVER. Claims for State Plan services provided to Medicaid recipients who also participate in the Aging Waiver may be submitted up to 12 months from the date of actual service.
- C. In the event a claim that was submitted within the allowable 90-day time frame is denied for another reason (such as an incorrect provider number or procedure code), THE PROVIDER MUST CONTACT THE BUREAU OF MEDICAID OPERATIONS [801-538-6155 (local) or 800-662-9651 (toll free in-state)] TO RESOLVE THE PROBLEM WITH THE INITIAL CLAIM. FILING A REPLACEMENT CLAIM AFTER THE 90-DAY DEADLINE WILL CAUSE THE REPLACEMENT CLAIM TO AUTO-DENY.

9 - 2 Calculating Claims Using TN Modifier

When using the TN rural enhancement modifier for a claim, providers should bill the total amount to be reimbursed (base amount and 1.75 increase). The Medicaid MMIS system computes the Maximum Allowable Base Rate in the MMIS system reference file multiplied by 1.75 and compares that number to the actual billed amount. The MMIS system then pays the actual billed amount up to the Maximum Allowable Rate X 1.75.

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10 SERVICE PROCEDURE CODES

The procedure codes listed below are covered by Medicaid under the Aging Waiver.

AGING WAIVER CODES Effective: July 1, 2006		
WAIVER SERVICE	CODE	UNIT OF SERVICE
Adult day health, licensed	S5102	per day
Case management, base	T1016	15 minute
Case management, rural enhancement	T1016TN	15 minute
Chore services, base	S5120	15 minute
Chore services, rural enhancement	S5120TN	15 minute
Adult Companion Services	S5135	15 minute
Adult Companion Services, rural enhancement	S5135TN	15 minute
Personal attendant program training services	S5115	15 minute
Personal attendant program training services, rural enhancement	S5115TN	15 minute
Environmental accessibility adaptations	S5165	per service
Home delivered supplemental meal, base	S5170	per meal
Home delivered supplemental meal, rural enhancement	S5170TN	per meal
Homemaker services	S5130	per hour
Homemaker services, rural enhancement	S5130TN	per hour
Personal attendant service, agency, base	T1019	per hour
Personal attendant service, agency, rural enhancement	T1019TN	per hour
Personal attendant service, independent contractor	S5125	15 minute
Personal emergency response system - purchase, rental, repair	S5160	each
Personal emergency response system - response center service	S5161	per month
Personal emergency response system - installation, testing, removal	S5162	each
Personal emergency response system - installation, testing, removal, rural enhancement	S5162TN	each

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Medication reminder system	S5185	per month
Respite care, unskilled, base	S5150	per hour
Respite care, unskilled, rural enhancement	S5150TN	per hour
Respite care, home health aide, base	T1005TE	per hour
Respite care, home health aide, rural enhancement	T1005TE, TN	per hour
Respite care, nursing facility	H0045	per day
Specialized medical equipment/supplies/assistive technology	T2029	each
Enhanced state plan supportive maintenance home health aide services, base	T1021	per hour
Enhanced state plan supportive maintenance home health aide services, rural enhancement	T1021TN	per hour
Transportation services (non-medical), base	T2003	one way trip
Transportation services (non-medical), rural enhancement	T2003TN	one way trip
Transportation services (non-medical), van, base	T2005	one way trip
Transportation services (non-medical), van, rural enhancement	T2005TN	one way trip

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